

# NEEDS ASSESSMENT FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

I.D.: \_\_\_\_\_ Counselor: \_\_\_\_\_

Instructions. Read the following to patients: Buprenorphine treatment is an opportunity to deal with a variety of problems and achieve a number of goals. The purpose of this questionnaire is to help me determine how I can best help you. Please answer these questions as best as you can. We will discuss a plan for your program here after you finish. (Ask patients if they would like help reading the form. If so, read through the form item by item.)

## I Drug Use

	Number days used in past month	Amount used on a typical recent day	Number years of regular use
A. Types of drugs used:			
1. Cannabis (marijuana, hashish)	_____	_____	_____
2. Cocaine (IV, smoke, or snort?) _____	_____	_____	_____
3. Amphetamines, methamphet. (IV, smoke, or snort?) _____	_____	_____	_____
4. Benzodiazepines (Valium, Xanax, Librium, etc.)	_____	_____	_____
5. Barbiturates (Seconal, Tuinal, etc.)	_____	_____	_____
6. Other Opiates (Darvon, Percocet, etc.)	_____	_____	_____
7. Hallucinogens (LSD, inhalants, etc.)	_____	_____	_____
8. Other (Specify) _____	_____	_____	_____

B. Have you ever been treated for problems with any of the above drugs?    \_\_\_Yes    \_\_\_No  
 If yes, which one(s)? \_\_\_\_\_  
 \_\_\_\_\_

C. How many days since last drug use?  
 Drug: \_\_\_\_\_ Days: \_\_\_\_\_ Amount: \_\_\_\_\_  
 Drug: \_\_\_\_\_ Days: \_\_\_\_\_ Amount: \_\_\_\_\_

D. Do you feel you have an addiction to or a problem with any of the drugs above? \_\_\_Yes    \_\_\_No  
 1. If yes, which drug(s)? \_\_\_\_\_  
 2. Do you think you will need help to stop?    \_\_\_Yes    \_\_\_No

## II. Alcohol Use

### A. Drinking history:

1. Number of years of drinking: \_\_\_\_\_
2. Number of years of heavy drinking (women: 3 or more drinks per day; men: 4 or more per day; men or women: 12 or more per week): \_\_\_\_\_
3. Kind(s) of alcohol consumed: \_\_\_\_\_
4. Amount of alcohol consumed weekly (approximate): \_\_\_\_\_  
Pattern: \_\_\_\_\_ Every day \_\_\_\_\_ Binge  
\_\_\_\_\_ Weekends \_\_\_\_\_ Other (specify: \_\_\_\_\_)
5. Have you had lapses of memory due to drinking? \_\_\_ Yes \_\_\_ No
6. Have you ever been arrested for an alcohol-related offense (e.g., drunk driving)? \_\_\_ Yes \_\_\_ No  
If yes, why? \_\_\_\_\_  
\_\_\_\_\_
7. Longest period of sobriety: \_\_\_\_\_ years \_\_\_\_\_ months
8. How many days since last drink? \_\_\_\_\_
9. Amount and type of alcohol last used: \_\_\_\_\_

### B. Treatment need:

1. Do you feel you have an addiction to or a problem with alcohol? \_\_\_ Yes \_\_\_ No  
If yes, describe \_\_\_\_\_
2. Do you think you will need help in order to stop drinking? \_\_\_ Yes \_\_\_ No
3. Have you ever been treated for alcohol problems before? \_\_\_ Yes \_\_\_ No  
If yes, describe: \_\_\_\_\_  
When: \_\_\_\_\_ Where: \_\_\_\_\_

### III. Social /Social Services

#### A. Friends:

1. How many close friends do you have? \_\_\_\_\_
2. How many of these are heroin users? \_\_\_\_\_
3. How many use alcohol or other drugs, but not heroin? \_\_\_\_\_
4. How many friends use no drugs? \_\_\_\_\_
5. How many friends use no drugs or alcohol? \_\_\_\_\_

#### B. Family:

1. What is your marital status?

Single \_\_\_\_\_ Married \_\_\_\_\_ Common Law \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

2. Do you have a spouse or partner? \_\_\_ Yes \_\_\_ No  
If yes, does this person use drugs or alcohol? \_\_\_ Yes \_\_\_ No

Describe: \_\_\_\_\_

3. How many children do you have? \_\_\_\_\_
4. Do your children live with you? \_\_\_ Yes \_\_\_ No
5. How many people live at your residence? \_\_\_\_\_
6. Do you feel you need relationship counseling? \_\_\_\_\_
7. Do you feel you need help in dealing with your children? \_\_\_ Yes \_\_\_ No

#### C. Social service need:

1. Source of income: How much of your *monthly* income do you receive from:

a. Job \$ \_\_\_\_\_ (indicate amount per month)

b. Welfare \$ \_\_\_\_\_

c. Unemployment \$ \_\_\_\_\_

d. Friends/family \$ \_\_\_\_\_

e. Illegal activities \$ \_\_\_\_\_

TOTAL \$ \_\_\_\_\_

2. How many people are dependent upon your income? \_\_\_\_\_
3. Do you think you are eligible for unemployment or public assistance (welfare)? \_\_\_ Yes \_\_\_ No

**IV. Psychological History/Status**

A. Have you had serious problems with any of the following during the past 30 days that were not related to drugs or alcohol?

- |  |                                   |
|--|-----------------------------------|
| _____ Depression   | _____ Paranoia                    |
| _____ Anxiety (worrying excessively)                         | _____ Aggressive/violent behavior |
| _____ Suicidal thoughts                                      | _____ Mood swings                 |
| _____ Imaginary voices or strange thoughts<br>or experiences | _____ Guilt or shame              |
| _____ Other (specify): _____                                 |                                   |

B. Have you ever been treated for a psychological problem(s)? \_\_\_Yes \_\_\_No

If yes, for what condition(s)? \_\_\_\_\_

When? \_\_\_\_\_

What type(s) of treatment? \_\_\_\_\_

Total number of treatment experiences: \_\_\_\_\_

C. Do you feel you have any psychological or marital problems now? \_\_\_Yes \_\_\_No

If yes, describe: \_\_\_\_\_

**V. Education**

A. Highest education completed:

- |                          |                        |
|--------------------------|------------------------|
| _____ 6th grade          | _____ 2-year college   |
| _____ 9th grade          | _____ College          |
| _____ High school or GED | _____ Graduate school  |
| _____ Some college       | _____ Technical school |
| (specify) _____          |                        |

B. Do you wish to or plan to return to school? \_\_\_Yes \_\_\_No

If yes, what is your goal? \_\_\_\_\_

**VI. Vocational**

A. Employment history:

1. Current employment status: (Check all that apply)

\_\_\_\_\_ Full time (hours and days): \_\_\_\_\_

\_\_\_\_\_ Part time (hours and days): \_\_\_\_\_

\_\_\_\_\_ Student (hours and days): \_\_\_\_\_

\_\_\_\_\_ Retired (since): \_\_\_\_\_

\_\_\_\_\_ Unemployed (since): \_\_\_\_\_

2. Are you receiving financial assistance, disability, or compensation?    \_\_\_ Yes    \_\_\_ No

3. Current or last occupation: \_\_\_\_\_

4. Longest period of work in the past 2 years: \_\_\_\_\_ years \_\_\_\_\_ months

B. Are you interested in job training?    \_\_\_ Yes    \_\_\_ No

If yes, what job or skill are you interested in

learning? \_\_\_\_\_

Are there any other problems or goals not addressed here that you would like me (us) to help you with?

\_\_\_ Yes \_\_\_ No If yes, describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_